received comparable dosages of sulfadiazine on two occasions after recovery from the urethral obstruction, without urinary complications.

SUMMARY

A case history of a child with urethral obstruction and anuria due to sulfadiazine crystals is presented. Stenosis of the external urethral meatus which was present in this case may have contributed to the blockage by narrowing the urethral channel. Treatment which consisted of discontinuing the drug, catheterization, meatotomy and forcing fluids by mouth, resulted in prompt recovery.

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Aneurysm of the Abdominal Aorta with Rupture into the Duodenum

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RUPTURE OF AN ANEURYSM into the gastrointestinal tract is rare. Hunt and Weller[2] who reported a case in 1946 found reports of only 40 cases in the literature. In 33 cases the rupture was into the duodenum. By 1951, 43 such cases had been reported.[1] The following is a report of an additional case.

REPORT OF A CASE

A 72-year-old white male one morning vomited a large amount of bright red blood after nausea and generalized abdominal distention of one week's duration. When examined about 15 minutes later the patient was in a state of shock. The systolic blood pressure was 110 mm. of mercury and diastolic pressure could not be measured. The patient refused hospitalization and was placed on a regimen of milk and Amphojel® every two hours. Tarry stools were passed. In the evening the blood pressure became stabilized at 130 mm. systolic and 80 mm. diastolic. During the night several large tarry stools were passed and the patient vomited a material having the appearance of coffee grounds. The next morning the patient collapsed in the bathroom and was taken to the hospital where he was admitted in a state of shock. Twenty years previously a diagnosis of peptic ulcer had been made following an episode of hematemesis. In the interim the patient had been in good health.

Upon physical examination, diffuse epigastric tenderness was noted, but there were no palpable abdominal masses or organs. The hemoglobin content of the blood was 10.5 gm. per 100 cc. Erythrocytes numbered 3.2 million per cu. mm. and leukocytes were 14,250—92 per cent polymorphonuclears, 6 per cent lymphocytes and 2 per cent monocytes.

Hematemesis and melena continued, necessitating four transfusions. Three days after admittance to the hospital the patient had sudden pain in the left side of the chest. Dyspnea and cyanosis developed and the patient died.

At autopsy the heart was observed to be of normal size; it weighed 350 gm. There was only minimal arteriosclerosis of the coronary arteries. A few pinpoint sized atheromatous plaques were present in the ascending aorta. There was moderate atherosclerosis of the abdominal aorta, with a saccular aneurysm containing a laminated thrombus situated just above the bifurcation. The aneurysmal sac was 3 cm. in diameter and 6 cm. in length and projected 3 cm. anteriorly. A probe was readily passed from the site of rupture in the anterior wall of the sac to a perforation in the duodenum (Figure 1). The perforation, which was 1 cm. in diameter, lay on the posterior aspect of the third portion of the duodenum, 2 cm. distal to the papilla of Vater (Figure 2). The stomach contained about 1,500 cc. of blood and clots. The

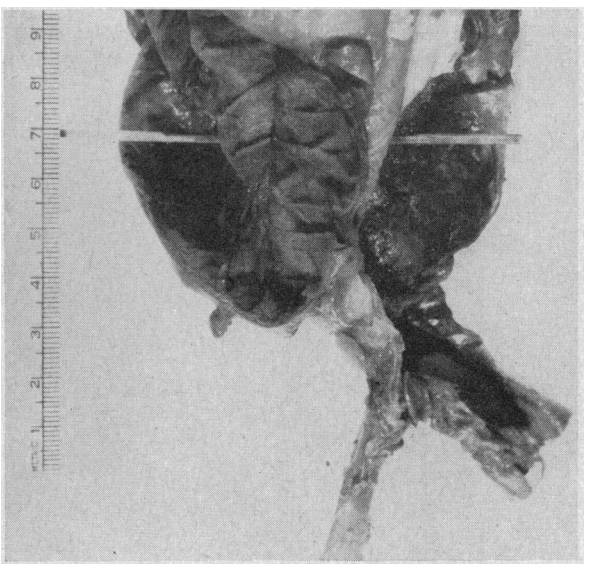

Figure 1.—A probe was passed from the site of rupture in the anterior wall of the sac to a perforation in the duodenum.

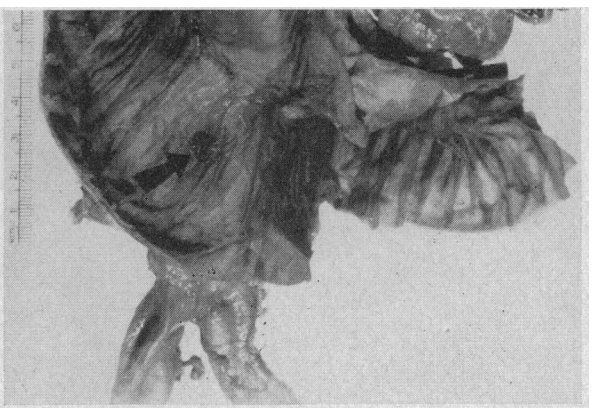

Figure 2.—Arrow points to perforation of the duo denum 2 cm. distal to the papilla of Vater.

proximal small bowel was filled with clotted blood. The colon contained tarry material. There was slight erosion of the anterior surfaces of the bodies of the third and fourth lumbar vertebrae.

In microscopic examination of sections taken at the level of the midthoracic aorta, intimal atheromatous deposits and atrophy of the media were observed. At the site of rupture, there was extensive hyalin change with loss of the smooth muscle and elastic tissue of the media; and a hyalinized thrombus was attached to the intima.

DISCUSSION

A correct clinical diagnosis was not made in the case here reported. The history of previous hematemesis due to peptic ulcer and the absence of a palpable abdominal mass indicated a clinical diagnosis of peptic ulcer. The terminal symptoms suggested coronary occlusion, but this diagnosis was not confirmed at autopsy.

With the inclusion of this case, there are 44 cases of abdominal aneurysm with rupture into the duodenum reported in the literature. In a previous report of eight cases observed in 16,633 autopsies,[1] it was noted that the lesion occurred in elderly persons; the average age in the eight cases was 72 years. Arteriosclerosis with or without hypertension was considered to be the most important cause of the lesion.

Rupture into the duodenum appears to be purely fortuitous, dependent on the proximity and fixation of the second and third portions of the duodenum to the lower abdominal aorta. Symptoms are usually of short duration, and pain is the usual initial manifestation. Melena and especially hematemesis are grave prognostic signs, suggesting a rapidly fatal outcome. A pulsating abdominal mass is usually present. Expansile pulsations are said to be highly suggestive of aneurysm,[4] and may be associated with a thrill or bruit over the mass. X-ray studies are frequently helpful in diagnosis.[3] Treatment is unsatisfactory and the prognosis is poor.

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